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MEDICAL MALPRACTICE LIABILITY CRISIS OR PATIENT COMPENSATION CRISIS?

Kathryn Zeiler*

INTRODUCTION

Tort reform has been a hot topic among those interested in assessing whether and how well the tort system aids injured plaintiffs' ability to achieve civil justice. The debate has been especially heated when it comes to medical malpractice liability. Proponents of malpractice liability reforms—reforms such as damages caps and shifts from joint and several liability to proportionate liability—argue that the broken and out-of-control liability system is error-prone and produces too many jumbo verdicts.¹ According to this argument, the huge and highly variable awards cause medical malpractice insurers to increase premiums, which leads to an increase in the cost of healthcare, an increase in the number of uninsured, and a decrease in the number of physicians who are willing to practice in jurisdictions that are sometimes labeled as “judicial hellholes.”²

Tort reform opponents, on the other hand, tend to argue that limitations on recovery or access to the tort system violate constitutional rights and that some reforms do more harm than good. For example, they claim that damages caps make it difficult for a subset of negligently injured plaintiffs to find a lawyer who is willing to pursue a legal claim on a contingency fee basis. Opponents also argue that the liability system is not the cause of insurance premium spikes;³ thus, reforms should not be expected to stabilize premiums, at least in the

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1. See discussion *infra* Part II.

2. See *infra* notes 21–27, 45, 72–73, 82 and accompanying text; William Lamb, *Pro-Lawsuit Group Wants President's Ear*, ST. LOUIS POST-DISPATCH, Jan. 5, 2005 (characterizing Madison and St. Clair counties, in Illinois, as “judicial hellholes”).

3. See discussion *infra* Part II.

long run.⁴ Some opponents further argue that the unreformed tort system does not do enough to compensate negligently injured patients.⁵

Until recently, rhetoric about the liability system and its relationship to both insurance markets and provider supply dominated tort reform debates. While claims made by both proponents and opponents may seem intuitive, they are often unsubstantiated. In recent years, however, academics and others have acquired or created datasets to perform analyses with the purpose of enhancing our understanding of the relationship between the tort system and medical malpractice insurance markets. These studies have helped to shift tort reform debates away from rhetoric and toward inferences drawn from facts that are reported in empirical studies.

While empirical research has been useful in shifting policy debates from rhetoric to reality, not all aspects of the tort reform debate have been empirically addressable. Most notably, although the vast majority of medical malpractice cases are resolved through private settlements between medical malpractice insurers, providers, and patients, researchers have been historically unable to observe settlement outcomes.⁶ This limitation has, in turn, limited our ability to observe both the impact of the liability system on important outcomes and the impact on the liability system of changes to the legal rules. Recently discovered datasets collected by state insurance departments, however, have provided a window into settlement outcomes, allowing us to examine important connections between liability systems and insurance markets.⁷ Using these datasets we have been able to track, for the first time in some cases, comprehensive trends in the number of claims and the size of payouts over time; potential impacts of tort re-

4. We might expect short-term decreases in premiums if insurers expect reduced losses. If reforms do not in fact reduce losses, however, insurers are forced to increase prices to compensate for short-term underpricing.

5. See David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 285 (2004) ("Only 2 percent of negligent injuries resulted in claims"); accord Patricia Born, W. Kip Viscusi & Tom Baker, *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*, 76 *J. RISK & INS.* 197, 198 (2009).

6. See VASANTHAKUMAR N. BHAT, *MEDICAL MALPRACTICE* 32 (2001); Patricia Munch Danzon & Lee A. Lillard, *Settlement out of Court: The Disposition of Medical Malpractice Claims*, 12 *J. LEGAL STUD.* 345, 347 (1983); Stephen J. Spurr & Walter O. Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 *J. HEALTH POL. POL'Y & LAW* 315, 323 n.16 (1996).

7. See, e.g., Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002*, 2 *J. EMPIRICAL LEGAL STUD.* 207, 209 (2005) (describing Texas's closed claims medical malpractice dataset); Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 *DEPAUL L. REV.* 315, 318 (2005) (describing Florida's closed medical malpractice dataset).

form on recoveries; connections between policy limits and payouts; trends in purchases of coverage over time; and trends in defense costs.⁸

The Texas Department of Insurance (TDI) was one of the first state insurance departments to collect and make publicly available claims-level data on closed medical malpractice claims.⁹ TDI began collecting and reporting data on closed claims in the late 1980s, following a sharp rise in medical malpractice insurance premiums.¹⁰ When a Texas insurer closes a medical malpractice claim, it is required to report certain information about payments, patient characteristics, litigation outcomes, timing of litigation procedures and outcomes, location where the injury occurred, jurisdiction of the lawsuit, and characteristics of other defendants and payments made by each.¹¹ During the period from 1988 to 2005, Texas insurers filed roughly 16,000 reports related to closed medical malpractice claims.¹²

8. See Black et al., *supra* note 7; David A. Hyman et al., *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003*, 4 J. EMPIRICAL LEGAL STUD. 3, 5 (2007) [hereinafter Hyman et al., *Defendants Pay*]; David A. Hyman et al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. LEGAL ANALYSIS 355, 355 (2009) [hereinafter Hyman et al., *Evidence from Texas*]; Kathryn Zeiler et al., *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990–2003*, 36 J. LEGAL STUD. S9, S9 (2007).

9. See TEX. DEP'T OF INS., 1997 TEXAS LIABILITY INSURANCE CLOSED CLAIM ANNUAL REPORT (1997), available at <http://www.tdi.state.tx.us/reports/report4.html> (last visited July 13, 2009).

10. See Black et al., *supra* note 7, at 208, 215 (describing the data collected by the Texas Department of Insurance (TDI)). The description of the data in the text is attributed to Black et al. unless otherwise indicated. A “claim” in this context is a request by an insured provider for indemnification for an incurred or expected loss from an insured peril. See TEX. DEP'T OF INS., TEXAS CLOSED CLAIM REPORTING GUIDE (2004) [hereinafter REPORTING GUIDE] (on file with author). Claims filed by the insured are not always accompanied by the filing of a lawsuit. A claim is considered closed when the insurer has made all indemnity and expense payments on the claim. See *id.* TDI has audited the data for completeness and accuracy (but for only some variables) since 1990. Black et al. exclude 1988–1989 when reporting number of claims due to potential incompleteness. See Black et al., *supra* note 7, at 215.

11. See REPORTING GUIDE, *supra* note 10. TDI does some work to audit reports. See Black et al., *supra* note 7, at 215.

12. See Hyman et al., *Evidence from Texas*, *supra* note 8, at 364. The data TDI collects vary according to the size of the total known payment to the claimant by all defendants. For claims with payments less than \$24,999, insurers are not required to report the cause of the injury; therefore, separating medical malpractice claims from other types of claims is impossible. For this reason, most results are produced using only “large” claims—those with total payments of at least \$25,000. In addition, TDI does not adjust the reporting threshold from year to year. Therefore, the number of claims reported as large claims will increase over time due in part to inflation. To control for this, we exclude claims with payouts measured in 1988 dollars that fall between \$25,000 (nominal) and \$25,000 (1988 dollars). For example, we excluded all claims closed in 1989 with payouts between \$25,000 and \$26,205 (buying power of \$25,000 in 1988 dollars).

Datasets like the one TDI generates and distributes allow us to better assess the liability system's ability to deliver just outcomes. They also allow us to verify or challenge claims made by proponents and opponents of tort reform, assess the impacts of tort reform on important outcomes, and better understand the relationship between the liability system and insurance markets. Instead of supporting claims made by those who blame medical malpractice liability system crises for rising insurance premiums, results using closed claims data, when taken as a whole, suggest that we might instead be facing a patient compensation crisis.

This Article is organized as follows. Part II summarizes the common rhetoric in tort reform debates that places the blame for rising premiums on the liability system and touts tort reform as the cure-all for ailing insurance markets.¹³ It then summarizes empirical results, produced using Texas closed claims data and other data, which suggest not only that Texas tort reform advocates wrongly placed blame on the liability system, but also that noneconomic damages caps passed in 2003 have caused more harm than good.¹⁴ Part III describes results that suggest that the widely used tactic of pointing to jumbo jury verdicts to justify tort reform is misguided.¹⁵ While verdicts and payouts are positively correlated, patients and their lawyers, on average, recover only fifty-six cents of each dollar awarded.¹⁶ In addition, the larger the verdict, the lower the fraction paid.¹⁷ While judicial oversight and damages caps explain about a third of the difference between verdicts and payouts, the largest chunk of the difference is explained by the fact that patients rarely recover more than the provider's insurance policy limits. This finding is cause for concern, especially given the fact that coverage purchased by Texas physicians is lower than conventional wisdom would predict and is continually on the decline.¹⁸ The data paint a picture not of a liability system in crisis, but of a patient compensation crisis, one that might severely limit the ability of the liability system to deliver civil justice to negligently injured patients.

13. See *infra* notes 19–44 and accompanying text.

14. See *infra* notes 46–71 and accompanying text.

15. See *infra* notes 72–127 and accompanying text.

16. See Hyman et al., *Defendants Pay*, *supra* note 8, at 4.

17. *Id.*

18. See discussion *infra* Part III.C.

II. THE TORT REFORM DEBATE

In 1999, Texas medical malpractice insurers started to sharply increase insurance premiums.¹⁹ Some insurers continued to increase rates through 2003.²⁰ Proponents of tort reform argued that an out-of-control liability system was causing the sudden and sharp premium increase.²¹ Specifically, they maintained that medical malpractice insurers had no choice but to increase premiums both because the number of claims and the size of payments were on the rise, and because juries were increasingly handing down outrageously large damages awards.²² They also claimed that the broken liability system regularly and handsomely rewarded sympathetic plaintiffs who brought frivolous claims.²³

In 2003, the Texas legislature passed a tort reform package that included caps on noneconomic damages in an effort to address the perceived insurance and tort system crisis.²⁴ During the run-up to passage, supporters claimed that “[c]apping noneconomic damages at reasonable limits would encourage insurers to do business in Texas by ensuring that they would not incur massive losses because of large damage awards.”²⁵ Some went further to claim that public resources were at stake: Texas Senator Robert Deuell argued during floor debate that “[w]hen noneconomic damages are excessive, it’s really not the defendant . . . that pays. It’s the other people who pay into the insurance plans.”²⁶ Deuell went on to assert that taxpayers ultimately pay for excessive awards.²⁷

19. See Black et al., *supra* note 7, at 224 fig.1.

20. *Id.*

21. Eric Torbenson & Jason Roberson, *Tort Reform: Is This Change Healthy?*, DALLAS MORNING NEWS, June 17, 2007, at 1A, 14A; Texans for Lawsuit Reform, Texas Urgently Needs Tort Reform to Avert Further Damage to Healthcare System, <http://www.tortreform.com/node/173> (last visited July 13, 2009).

22. See Torbenson & Roberson, *supra* note 21, at 14A.

23. See Texans for Lawsuit Reform, *supra* note 21; Mike Thomas, Op-Ed., *Medical Malpractice Needs an Overhaul*, ORLANDO SENTINEL, Sept. 6, 2009, at B1.

24. HOUSE RESEARCH ORG., FOCUS REPORT OF CONSTITUTIONAL AMENDMENTS PROPOSED FOR SEPT. 2003 BALLOT, H.R. No. 78-10, at 33. (2003), available at <http://www.capitol.state.tx.us/focus/amend78.pdf>. In addition to caps on noneconomic damages, the tort reform package included other provisions meant to reduce expected liability such as modifications to joint and several liability rules and the possibility of periodic payments. See Ronen Avraham, *Database of State Law Tort Reforms (DSTLR, 2nd)* 116–18 (Nw. Univ. Sch. of Law, Law & Econ. Research Paper No. 06-08, 2006), available at <http://ssrn.com/abstract=902711>.

25. HOUSE RESEARCH ORG., FOCUS REPORT OF CONSTITUTIONAL AMENDMENTS PROPOSED FOR SEPT. 2003 BALLOT, H.R. No. 78-10, at 33 (2003), available at <http://www.capitol.state.tx.us/focus/amend78.pdf>.

26. *Id.*

27. Black et al., *supra* note 7, at 231 fig.4.

While rhetoric often takes center stage in tort reform debates, recent compilation and dissemination of comprehensive datasets on closed medical malpractice insurance claims has allowed us to observe actual trends in medical malpractice litigation and to get a better handle on the relationship between the liability system and insurance markets. Empirical analyses of Texas's closed claims data have helped to evaluate whether trends in the liability system actually justified the noneconomic damages cap passed in Texas and whether and to what extent the cap might impact litigation outcomes. The studies suggest that much of the rhetoric missed the mark.

A. Did Conditions Warrant Caps and Other Reforms?

The Texas closed claims data have been used to test multiple claims of tort reform proponents. With respect to the number of claims, the data do not support rhetorical claims that the number of medical malpractice claims steeply increased prior to the passage of the statutory noneconomic damages cap. Instead, the data demonstrate that the per capita claims rate was stable from 1990 to 2002.²⁸ Whether growth rates are measured using total number of claims per year, number of large paid claims, or percentage of claims that resulted in large payouts, the conclusion is the same: the number of large paid claims did not increase over time.²⁹ In fact, when we control for changes in the number of practicing physicians or growth in inflation-adjusted healthcare spending, we find that the number of large paid claims decreased.³⁰ Both the number of claims with payments of less than \$10,000 and with payments between \$10,000 and \$25,000 appear stable over time.³¹

How about claims related to payment size prior to the passage of the 2003 damages cap? More specifically, do the data support claims that payment size was skyrocketing during the late 1990s and early 2000s? Again, the empirical results suggest that these assertions were greatly exaggerated. Despite the variability and possible increase in the average damages awards from 1988 to 2002,³² payouts per claim

28. *Id.*

29. *Id.* Adjusting for population growth, the number of physicians, and healthcare spending allows us to control for changes in claims rates due to changes in the number of Texas residents. *Id.* It is important to control for changes in these variables because if, for example, we find that claims rates increased due to a population increase, we would not characterize the claims rate increase as a crisis. It is something that we would expect.

30. *Id.* at 231 fig.4, 233 tbl.1.

31. *Id.* at 234 fig.5.

32. *Id.* at 249-51.

were either relatively stable or slightly increased.³³ After controlling for the increase in healthcare costs, which is a significant component of amounts paid to injured patients, average payouts were either stable or declined over time.³⁴ Defense costs per large paid claim increased over the period but did so gradually.³⁵ In addition, defense costs comprise only a small fraction of payout dollars.³⁶ As a percentage of Texas gross state product, the total cost for all large paid claims (including inflation-adjusted indemnified amounts and defense costs) was roughly flat over 1990–2002.³⁷ Thus, the gradual increase in total costs during the late 1990s is likely explained by a predictable increase in medical costs, not an out-of-control liability system.³⁸

These results, taken together, suggest that the data do not support those who use claims about the state of the medical malpractice liability system in Texas in order to justify tort reform. Contrary to the assertions of tort reform proponents, closed claims data suggest little connection between the liability system and premium fluctuations.³⁹

If a broken liability system was not behind the sharp increase in insurance premiums during the late 1990s and early 2000s, it raises the question, what was? One possibility is that increases were the unintended consequence of price regulations. Specifically, when Texas passed its 1995 tort reform package, it also imposed a mandatory insurance premium reduction based on expected losses to ensure that the predicted savings of insurers would be passed on to healthcare providers.⁴⁰ Prices declined for three years, reflecting the belief of the insurers and regulators that tort reform would reduce losses. Sharp

33. *Id.* at 238 fig.9. Note that while median payouts remained stable from 1996 to 2000, the mean payout increased from roughly \$280,000 to \$360,000 (a twenty-nine percent increase). Insurance premium increases, however, far outpaced this increase. *See id.* at 224 fig.1.

34. *Id.* at 237–41.

35. *Id.* at 243 fig.11.

36. *Id.* at 245. Data on zero payout and small payout claims are unavailable; therefore, it is impossible to estimate the change in total defense costs over time. Black et al., however, cast doubt on the possibility that defense costs caused the sharp premium increases. *Id.*

37. *Id.* at 248 fig.13.

38. *Id.* at 248.

39. Black et al. note that because data on open claims is unavailable premium increases might in fact be due to an increase in the number of claims or an increase in expected payouts on open claims. *See id.* at 210. While the data employed in their study cannot rule out this possibility, the authors argue that it is unlikely. *See id.* at 210, 218–19. In any event, this hypothesis will be testable as open claims close and reports are filed with TDI. In addition, TDI does not collect data on physician specialty. Therefore, the data cannot be used to study connections between the liability system and insurance markets for subsets of physicians that are particularly hard hit by insurance premium increases (e.g., obstetricians). Despite this limitation, the data are useful for debunking more general rhetorical claims.

40. *See* TEX. INS. CODE ANN. § 5.131 (Vernon 2006) (repealed Apr. 1, 2007).

price increases, however, began in 1998.⁴¹ This observation is consistent with the theory that tort reform did not reduce losses as much as expected and that insurers were forced to substantially increase rates (and regulators were forced to honor these rate increase requests) in order to replenish their reserves that were hit hard by the below-cost pricing following tort reform.⁴² Black et al. posit additional alternative explanations, including contemporaneous shocks to reinsurance markets and the long-tail nature of medical malpractice claims.⁴³ Ultimately, further study is required to uncover the cause of price increases in Texas.

While data limitations—such as unobservable defense costs and the lack of information on the impact of the liability system across medical specialties⁴⁴—might hinder our ability to draw definitive conclusions regarding whether the liability system is responsible for the sharp increase in premiums, empirical studies are helpful in shifting the debate away from rhetoric and toward reality. Analyses of this kind can help shift the burden of proof to tort reform proponents by compelling them to substantiate their claims with evidence. As the next Section demonstrates, empirical studies can also help determine whether tort reforms are successful.

B. Have Reforms Met Their Intended Goals?

In debates over whether to reform the liability system in order to stem the rise of medical malpractice insurance premiums, rhetoric about the potential impacts of tort reform is as common as rhetoric about the out-of-control liability system. Proponents of tort reform often point to evidence produced by industry players with an interest in the outcome of the debate, suggesting that implementation of damages caps, limitations on joint and several liability, reform of collateral source rules, tightening of statutes of limitations, and other reforms have a substantial impact on medical malpractice insurance premiums.⁴⁵

Recent studies, however, have demonstrated fairly convincingly that tort reforms do not substantially reduce insurance premiums.

41. See Black et al., *supra* note 7, at 254.

42. See *id.* I am currently constructing a multistate dataset to investigate this conjecture.

43. *Id.* at 253–54.

44. Texas does not require reporting of defense costs when small payouts are made. See *supra* note 12. It also does not require insurers to report the provider's specialty. See *supra* note 9.

45. See e.g., Am. Tort Reform Ass'n, Facts About Tort Liability and Its Impact on Consumers, http://www.atra.org/wrap/files.cgi/7963_howtortreform.html (last visited Dec. 14, 2009) (providing information about the costs of the U.S. tort system; figures are from a 2004 report by Tillinghast, an insurance industry consultancy).

Empiricists have investigated the impacts of various tort reforms on claims rates, average payouts, and insurance premiums. The results, some of which are summarized below, suggest that reforms have little to no impact on these variables, although the most restrictive damages caps seem to have some impact.⁴⁶

While some evidence suggests that joint and several liability limitations are associated with lower premiums,⁴⁷ other results suggest that these limitations do not decrease payouts.⁴⁸ Although, to my knowledge, we do not have evidence about this reform's impact on the claims rate, the evidence related to premiums and payouts in Texas is consistent with the conjecture that, in the absence of an effect of joint and several liability reform on average payouts, mandatory price decreases, passed in conjunction with tort reforms, caused the observed price decreases.

Findings related to the impacts of statutes of limitations and repose reforms are also mixed. Some studies suggest that these reforms reduce average payouts;⁴⁹ some suggest they do not.⁵⁰ Other studies suggest that these reforms reduce claim frequency;⁵¹ some find they do not.⁵² Similarly, some studies conclude that these reforms reduce

46. All studies cited in this section use sophisticated methods to estimate effects and control for alternative explanations.

47. See Glenn Blackmon & Richard Zeckhauser, *State Tort Reform Legislation: Assessing Our Control of Risks*, in *TORT LAW AND THE PUBLIC INTEREST: COMPETITION, INNOVATION, AND CONSUMER WELFARE* 272, 274–75 (Peter H. Schuck ed., 1991); Patricia M. Danzon, Andrew J. Epstein & Scott J. Johnson, *The Crisis in Medical Malpractice Insurance*, in *BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES* 55, 82 (R. Harris & R. Litan eds. 2004); W. Kip Viscusi et al., *The Effect of 1980s Tort Reform Legislation on General Liability and Medical Malpractice Insurance*, 6 J. RISK & UNCERTAINTY 165, 165 (1993). But see Kenneth E. Thorpe, *The Medical Malpractice "Crisis": Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF. W4-20, W4-25 to W4-26 (Supp. Web Exclusives Jan. 21, 2004), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1/DC1>.

48. See Ronen Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J. LEGAL STUD. S183, S206 (2007); Blackmon & Zeckhauser, *supra* note 47, at 277; Viscusi et al., *supra* note 47, at 181–82; Teresa M. Waters et al., *Market Watch: Impact of State Tort Reforms on Physician Malpractice Payments*, 26 HEALTH AFF. 500, 508 (2007).

49. See Patricia Danzon, *The Frequency and Severity of Malpractice Claims*, 27 J.L. & ECON. 115, 139 (1984).

50. See Frank A. Sloan, Paula M. Mergenhagen & Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. HEALTH POL. POL'Y & L. 663, 674 (1989); Stephen Zuckerman, Randall R. Bovbjerg & Frank A. Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 180 (1990); Blackmon & Zeckhauser, *supra* note 47, at 278; Waters et al., *supra* note 48, at 507.

51. See Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57, 71 (1986); Zuckerman et al., *supra* note 47, at 167.

52. See Danzon, *supra* note 49, at 116.

premiums,⁵³ but others find no association between the reforms and premiums.⁵⁴ Further investigation of the impacts of statutes of limitations and repose reform is required in order to more confidently assess how these reforms affect outcomes.

The literature, however, does signal consensus on the impacts of a number of reforms, including attorney contingency fee limits, collateral source offsets, pretrial screening panels, and periodic payments.⁵⁵ The majority of published studies find that these reforms do not decrease claim frequency, payment severity, or premiums. The general rhetoric prevalent in tort reform debates might account for the continued popularity of these reforms despite the strong evidence that they do not achieve their intended goals.

The evidence on the effectiveness of damages caps—the most popular tort reform—is mixed.⁵⁶ Some analysts find that caps on noneconomic damages do not significantly lower premiums.⁵⁷ Others find that states have enjoyed premium reductions when they cap both economic and noneconomic damages or when they implement relatively restrictive caps.⁵⁸ Likewise, some analysts find that caps lead to small decreases in defensive medicine,⁵⁹ but others find no effect.⁶⁰ In particular, Morrissey et al. find no impact of caps on health insurance premiums for employer-sponsored insurance,⁶¹ while Avraham and Schazenbach find (1) a positive association between caps on total damages and rates of private healthcare coverage for price-sensitive

53. See Zuckerman et al., *supra* note 50, at 167.

54. See Blackmon & Zeckhauser, *supra* note 47, at 287; Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629, 629 (1985).

55. See Michelle Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms* 10 (Robert Wood Johnson Foundation Research Synthesis Report, 2006), available at <http://www.policysynthesis.org>.

56. See *id.* at 9–11.

57. See BHAT, *supra* note 6, at 109; Zuckerman et al., *supra* note 50, at 180.

58. See BHAT, *supra* note 6, at 101–03; Danzon et al., *supra* note 47, at 89; Meredith L. Kilgore, Michael A. Morrissey & Leonard J. Nelson, *Tort Law and Medical Malpractice Insurance Premiums*, 43 INQUIRY 255, 255 (2006); Thorpe, *supra* note 47, at W4-20; Zuckerman et al., *supra* note 50, at 180.

59. See Daniel P. Kessler & Mark B. McClellan, *How Liability Law Affects Medical Productivity*, 21 J. HEALTH ECON. 931, 932 (2002).

60. See CONGRESSIONAL BUDGET OFFICE, *LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE* (2004), available at <http://www.cbo.gov/showdoc.cfm?index=4968&sequence=0> (finding that reducing tort liability does not reduce medical spending); see also Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for "Defensive Medicine"? A Reassessment*, 28 J. HEALTH ECON. 481, 481 (2009) (concluding that "tort reforms do not significantly affect medical decisions").

61. See Michael A. Morrissey, Meredith L. Kilgore & Leonard (Jack) Nelson, *Medical Malpractice Reform and Employer-Sponsored Health Insurance Premiums*, 43 HEALTH SERVICES RES. 2124, 2124 (2008).

buyers, and (2) no association between healthcare coverage and punitive and noneconomic damages caps.⁶² In sum, while damages caps have been found in some cases to achieve their intended goals, albeit having small impacts on outcomes, much evidence supports the claim that caps fail to stabilize medical malpractice insurance markets.

Due to the small number of claims closed post-cap, the Texas closed claims data cannot be used to accurately estimate the impacts of tort reform. David Hyman and his co-authors, however, used it to estimate the *hypothetical* impact of the 2003 noneconomic damages cap on payouts related to claims closed from 1988 to 2004.⁶³ Hyman et al. first estimate the impact the cap would have had on jury verdicts.⁶⁴ They then use this analysis to consider how the cap might have affected settlements.⁶⁵ The results comport with prior findings:⁶⁶ while caps would have had a substantial impact on damages awards at trial, the impact on actual payouts would have been much smaller, although substantial given the restrictive cap of \$250,000.⁶⁷ Most importantly, their findings provide clues as to why caps might not impact medical malpractice insurance premiums in predicted ways. Using insights from previous research that finds that payouts in Texas rarely exceed the provider's insurance policy limits, Hyman et al. note that damages caps that exceed average policy limits should not have a substantial impact.⁶⁸ Thus, while Hyman and his colleagues' analysis certainly cannot provide a completely accurate picture of how the cap would have impacted outcomes (because, for example, some claims would not have been brought at all had caps been imposed),⁶⁹ it does help explain, at least in part, why caps might not impact payouts and premiums in predicted ways.

62. See Ronen Avraham & Max M. Schanzenbach, *Impact of Tort Reform on Private Health Insurance Coverage* (Nw. Univ. Sch. of Law, Public Law and Legal Theory Series, Paper No. 07-16, 2007), available at <http://ssrn.com/abstract=995270>.

63. Hyman et al., *Evidence from Texas*, *supra* note 8, at 355.

64. *Id.* at 364–65.

65. *Id.* at 370–72.

66. See *infra* notes 83–87 and accompanying text.

67. Hyman et al., *Evidence from Texas*, *supra* note 8, at 405 (“We find that this cap will have economically significant effects. For tried cases, holding case mix constant, the cap will reduce allowed noneconomic damages by an estimated 73%, allowed verdicts by 38%, and payouts by 27-percent. In settled cases, the estimated decline in payouts is 18%.”).

68. See *infra* notes 99–110 and accompanying text (discussing the impact of policy limits on payouts).

69. In addition, the authors made a number of assumptions about how caps impact damages awards because they lacked important information such as the portion of economic damages attributed to medical expenses, to which the death cap does not apply. See Hyman et al., *Evidence from Texas*, *supra* note 8, at 366.

Empirical studies have not only demonstrated the general ineffectiveness of tort reform, but they have also exposed some potentially harmful impacts that tort reforms can have on subsets of the injured patient population. Using Texas closed claims data, Hyman et al. predict a disparate impact across plaintiff groups, with the deceased, unemployed, and (likely) elderly plaintiffs enduring much larger reductions in recoveries than other plaintiffs.⁷⁰ Mello reports results that demonstrate a similar effect for the most severely injured plaintiffs.⁷¹ The literature addressing this question is thin, however; more research is needed in order to better understand whether and how caps impact outcomes across various subsets of claimants. It should be noted, however, that relatively low recoveries are not the sole concern. Analysts must also consider the difficulty these types of patients will have in finding lawyers who are willing to represent them pursuant to contingency fee arrangements. This impact is difficult to estimate, but it remains an important part of the big picture.

Recent sophisticated empirical studies that examine the impacts of tort reform on the liability system and insurance markets make it difficult for proponents of tort reforms to claim that traditional reforms, such as damages caps, will substantially quell rising insurance premiums without reducing the neediest claimants' ability to recover. Data have certainly allowed more objective assessments of the trade-offs we face in exchange for potential marginal benefits obtained from implementing the most effective tort reforms.

III. DRAWING INFERENCES FROM LARGE VERDICT AWARDS

In addition to rhetoric on the connection between the liability system and insurance markets, tort reform debates are also often influenced by unsubstantiated claims related to trends in medical malpractice jury verdicts and how these verdicts impact eventual insurer payouts and premiums. Proponents of tort reform argue that out-of-control juries hold healthcare providers liable for medical malpractice more often than they should⁷² and that juries have been awarding plaintiffs increasingly large amounts of damages, which

70. *See id.* at 381–82.

71. *See Mello, supra* note 55, at 13.

72. *See, e.g.,* Peter Baker, *Bush Campaigns to Curb Lawsuits*, WASH. POST, Jan. 6, 2005, at A6. Bush surrounded himself with doctors in white coats to argue that “junk lawsuits” were driving physicians out of places such as Collinsville, ranked by advocates as the friendliest place in the United States for trial lawyers chasing big awards. “You see firsthand what happens when the system gets out of control,” he told a crowd of supporters.

Id.

forces insurers to either substantially increase premiums or exit the market.⁷³

A recent empirical study by David Studdert and others provides one of the first assessments of tort reform proponents' claims that medical liability system error rates are excessively high.⁷⁴ They find that error rates are lower than tort reform proponents often claim.⁷⁵ In roughly 73% of claims in which physicians concluded that medical error caused the plaintiff's injury, the plaintiff received compensation. In addition, in roughly 72% of claims in which no medical error was found, plaintiffs received no compensation.⁷⁶ The authors also find that payment size is positively correlated with whether a medical error occurred.⁷⁷ These findings suggest that the liability system's error rate, while substantial and cause for concern, is not as high as some have claimed.⁷⁸

Recent empirical findings also allow us to assess claims about trends in Texas medical malpractice verdicts and how verdicts impact payouts and premiums. Section A summarizes recent findings, which suggest that despite an increase in Texas medical malpractice jury awards, payouts have remained stable over time.⁷⁹ Section B describes evidence that might help explain this counterintuitive finding. The evidence suggests that insurance policy limits tend to limit payouts regardless of verdict size. Patients rarely recover more than the provider's policy limit, even when juries award large verdicts.⁸⁰ Finally, Section C presents findings that are consistent with the claim that Texas physicians are strategically decreasing their insurance coverage,

73. See, e.g., James Dao, *A Push in States to Curb Malpractice Costs*, N.Y. TIMES, Jan. 14, 2005, at A21 ("[M]any insurance companies had stopped issuing policies, reducing competition and causing premiums to rise."); Sheryl Gay Stolberg, *Senate Rejects Award Limits in Malpractice*, N.Y. TIMES, May 9, 2006, at A25 ("Mr. Frist and other supporters of revamping malpractice law, including the American Medical Association, have argued for years that rising insurance rates, fueled by skyrocketing jury awards, are driving doctors out of business and compromising patient care.").

74. See David Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2024 (2006).

75. *Id.* at 2031.

76. *Id.* at 2027–28.

77. *Id.* at 2024.

78. *Id.* at 2031 ("[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown."). It is important to note that physicians who reviewed the medical records associated with these cases had access to the litigation outcome, which might have influenced their medical error determinations. See *id.* at 2031–32 (cautioning the reader about several limitations of the study). Additional research is required to confirm conclusions drawn from the study about the liability system error rate.

79. See discussion *infra* Part III.A.

80. See discussion *infra* Part III.B.

which might further reduce payments that injured patients receive.⁸¹ While additional research is necessary to more fully understand the relationship between the liability system and insurance markets, the current evidence suggests that Texas might be experiencing a patient compensation crisis, rather than a medical malpractice liability crisis.

A. *Verdicts v. Payouts*

Tort reform proponents often point to large verdict awards as evidence of a broken medical malpractice liability system. They argue that unjustified blockbuster awards encourage plaintiff attorneys, who typically work on a contingency fee basis, to play the “lawsuit lottery.”⁸² In addition, they claim that awards impact not only claims rates, but also settlement behavior of claimants and insurers. Fear of out-of-control juries, the argument goes, compels insurers to settle even nonmeritorious claims with large payments.

Using verdicts to predict settlement behavior, however, might lead to substantial errors if payouts and verdicts tend to diverge. Payouts can be lower than verdicts for several reasons: (1) adjustments made through remittitur, (2) appellate court reversals, (3) imposition of statutory damages caps, and (4) post-verdict settlement negotiations. Conversely, we expect payouts to exceed verdicts in some cases, such as when plaintiffs accept payments in exchange for foregoing the appeal of pro-defendant verdicts. Therefore, data on verdicts might lead to false impressions about the amount of money that changes hands. Actual payments have been notoriously difficult to estimate, given the lack of available data on settlements.

My co-authors and I used the Texas data on claims closed from 1988 to 2003 to estimate differences between verdicts and payouts.⁸³ We find that payouts fall far short of verdicts in the vast majority of “large claim” cases—cases with total payouts of at least \$25,000 in 1988 dollars.⁸⁴ While jury verdicts and payouts are positively correlated, 75% of post-verdict payments were lower than the adjusted verdict, which is defined as jury award plus pre- and post-judgment interest.⁸⁵ An analysis of 306 verdicts handed down in large claim cases closed from

81. See discussion *infra* Part III.C.

82. See generally JEFFREY O'CONNELL, *THE LAWSUIT LOTTERY: ONLY THE LAWYERS WIN* (1979).

83. See Hyman et al., *supra* note 8, at 3. Of 13,269 incidents of alleged malpractice that resulted in payouts of at least \$25,000 (in 1988 dollars), 690 (5.1%) went to trial and 315 (2.7%) resulted in a verdict. *Id.* at 16 tbl.2. Fifteen cases that involved bench trials were excluded from the analysis. *Id.*

84. *Id.* at 4.

85. *Id.* at 5. Five percent of payouts following verdicts exceeded adjusted verdicts. *Id.* at 6.

1988 to 2003 revealed that plaintiffs received only 56% of total adjusted verdicts (\$212 million total payouts following adjusted verdicts totaling \$482 million).⁸⁶ The mean per-case “haircut” was 29% of the adjusted verdict, and the median was 19%.⁸⁷

In addition, the study finds that haircuts and adjusted verdicts are positively correlated. Forty-seven percent of plaintiffs who were awarded adjusted verdicts of less than \$100,000 experienced an average haircut of 8% per case.⁸⁸ In contrast, ninety-eight percent of plaintiffs who were awarded adjusted verdicts in excess of \$2.5 million experienced an average haircut of 56%.⁸⁹ As the adjusted verdict increases, both the percentage of cases taking a haircut and the average per-case haircut increase.⁹⁰ These findings underscore the difficulties inherent in justifying tort reform by pointing to verdicts, often widely reported by the press, and ignoring eventual payouts, which the press almost never reports.

While accounting for the differences between verdicts and payouts is important, understanding why these differences occur will better our understanding of the tort system’s inner workings. The following Section summarizes findings that illuminate the various factors that drive the verdict-payout discrepancy.

B. Explaining the Discrepancy

Remittitur, appellate court reversals, imposition of damages caps, and post-verdict settlement negotiations account for a portion of the \$270 million that Texas plaintiffs were awarded from 1988 to 2003 but never received.⁹¹ The data TDI collects allow us to estimate the impact of various mechanisms that aim to limit post-verdict payments.

Judicial oversight in the form of remittitur, judgment notwithstanding the verdict (JNOV), and appellate reversals had a small direct impact on haircuts.⁹² Judges reduced verdicts through remittitur in roughly 5% of cases, for a total reduction of approximately \$9 million (3.3% of the total haircut).⁹³ JNOV and appellate reversals also ac-

86. *Id.* at 25.

87. *Id.* See *id.* at 14, for details on how pre- and post-judgment interest were computed.

88. *Id.* at 6.

89. *Id.*

90. *Id.* at 32 tbl.10.

91. *Id.* at 4–6.

92. *Id.* at 6. It should be noted that judicial oversight might indirectly impact post-verdict settlement negotiations. This indirect impact is impossible to measure; therefore, we likely underestimate the influence of judicial oversight on haircuts.

93. *Id.* at 35. If reversed remittiturs are excluded, the total reduction is approximately \$5.5 million (2% of the total haircut). *Id.*

count for a small portion of the total haircut in large payout claims—roughly \$2.5 million of the \$270 million total haircut (about 1% of the total haircut).⁹⁴

During the period we studied, legislators required Texas courts to impose statutory caps on punitive damages and damages awarded in death cases.⁹⁵ The punitive damages cap reduced damages awards in 5 of the 22 cases in which punitive damages were awarded.⁹⁶ The total reduction was roughly \$44 million, which amounts to 62% of the awarded punitive damages and 16% of the total haircut. A cap on recovery in wrongful death cases applied in 66 cases.⁹⁷ The cap does not apply to medical expenses, and TDI does not report these expenses separately; thus, the impact of this cap is a rough estimate.⁹⁸ At most, however, we estimated that the wrongful death cap accounted for roughly \$38 million of the \$270 million total haircut (roughly 14% of the total haircut). Therefore, together, statutory caps accounted for approximately 30% of the total haircut. This estimate, plus the estimated impact of judicial oversight, leaves roughly two-thirds of the total haircut to be explained.

It turns out that the largest portion of the total haircut is due to the fact that plaintiffs rarely collect more than the provider's insurance policy limit, even when the adjusted verdict greatly exceeds the policy limit.⁹⁹ Figure 1 displays payout-to-policy-limit ratios for *single-payer* cases in which the policy limit was at least as large as the adjusted verdict and cases in which the adjusted verdict exceeded the policy limit ("above-limits cases").¹⁰⁰ For cases in which the payout-to-policy-limit ratio was 100%, the payout was exactly equal to the policy limit. As Figure 1 reflects, 31% (24 out of 77) of above-limits single-payer cases had payouts between 95% and 105% of policy limits. A majority (53%) of above-limits cases settled at or below policy limits, with the limits effectively capping recovery.¹⁰¹ Depending on the as-

94. *Id.* at 36.

95. See *id.* at 12–13, for a description of the caps.

96. *Id.* at 36–37.

97. *Id.* at 38.

98. *Id.* We assumed that none of the economic damages were for medical expenses; therefore, we overestimated the impact of the wrongful death cap.

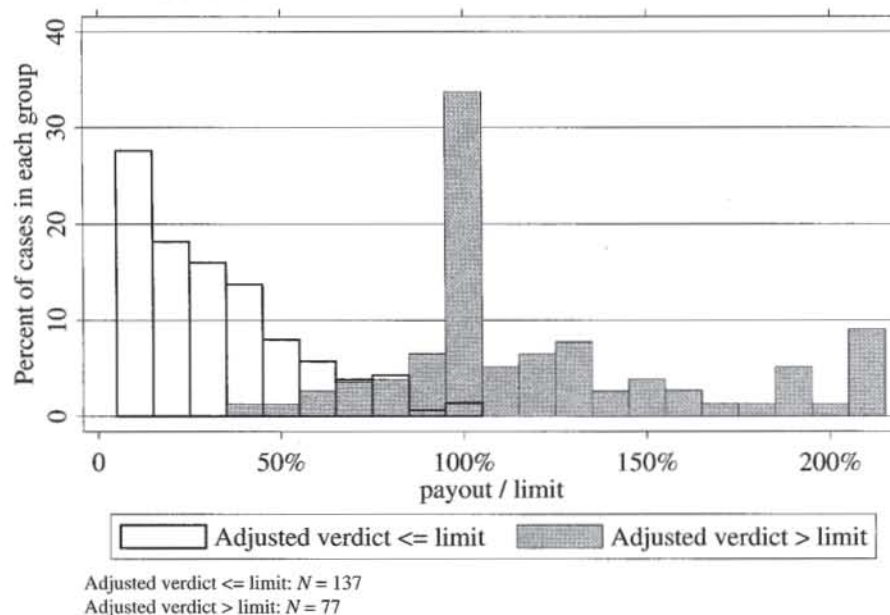
99. *Id.* at 39–47.

100. We included only single-payer cases in this analysis because we do not have full information about excess coverage in multi-payer cases. Of the 315 cases that went to verdict, 214 were single-payer cases with sufficient information on policy limits to analyze the impact of limits on payouts. *Id.* at 39. Caution should be used when drawing inferences from single-payer cases, however. For example, payouts related to single-payer cases are smaller than those for multi-payer cases. *Id.* at 15.

101. *Id.* at 41.

sumptions adopted to estimate the impact of policy limits on recoveries, policy limits account for 73% to 87% of total haircuts in single-payer cases.¹⁰² For this subset of cases, judicial oversight and caps explain only 1.5% to 15% of the total haircut, depending on estimation assumptions.¹⁰³

FIGURE 1: THE IMPACT OF LIMITS ON PAYOUTS¹⁰⁴



In a separate study, we analyzed the impact of policy limits on payouts in all claims *against physicians* with payouts of at least \$25,000 in 1988 dollars, including those that settle prior to verdict.¹⁰⁵ We find that policy limits act as de facto caps in these cases as well; only 1.5% of large payout claims had above-limit payments.¹⁰⁶ Interestingly, primary carriers funded most of these payments.¹⁰⁷ Physicians made out-of-pocket payments in only 62% of the 9,525 cases that closed from

102. *Id.* at 46. One estimate assumes that caps and remittiturs are applied first and then policy limits bind the payment. The other assumes policy limits bind the payment before caps and remittiturs have an impact.

103. *Id.*

104. *Id.* at 42 fig.6.

105. Zeiler et al., *supra* note 8, at S9.

106. *Id.* at S11.

107. *Id.* While we did not explore the reasons why insurers pay amounts above the limits, we conjecture that insurers make payments in some cases to avoid bad faith settlement claims by providers who wish to settle when the insurer wishes to defend the provider against the claim. *Id.* at S31.

1990 to 2003.¹⁰⁸ In addition, although we might expect more out-of-pocket payments in cases in which policy limits are low, we find that low policy limits did not trigger a flood of out-of-pocket payments by physicians.¹⁰⁹ Physicians with \$250,000 per occurrence policies made an out-of-pocket payment in only 32 of 2,488 claims (1.3%).¹¹⁰

While additional unobservable factors, such as high-low agreements, likely explain a portion of the total haircut, post-judgment settlements clearly play a substantial role in reducing payments to plaintiffs, even when the plaintiffs win large verdicts. This alone is cause for concern, given the primary goals of the tort system: to compensate negligently injured patients for their losses and to deter negligence. Concern might extend beyond this, however, if we consider how physicians might react as they learn that they face limited personal exposure even when injured patients might perceive them as being underinsured.

Although we do not fully understand why policy limits act as de facto caps on recoveries,¹¹¹ the Texas closed claim data provide some insights into coverage trends.¹¹² The following Section discusses the findings associated with policies purchased by Texas physicians who were involved in large paid claims.

C. Trends in Medical Malpractice Coverage and Implications for Tort Recoveries

The conventional wisdom seems to be that physicians hold medical malpractice insurance policies with \$1 million per-occurrence limits.¹¹³ The Texas closed claims data suggest otherwise, at least for policies that covered large paid claims closed from 1990 to 2003. The median policy limit for the subset of policies covering these claims was \$500,000 in nominal dollars.¹¹⁴ Only 31% of policies in the sample

108. *Id.* at S26.

109. *Id.* at S27.

110. *Id.*

111. *Id.* at S39.

112. *Id.* at S32–S34.

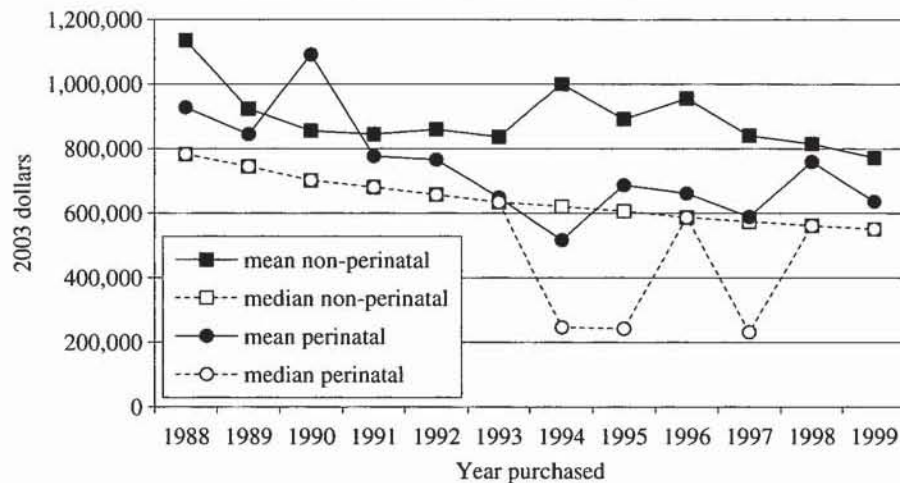
113. See, e.g., Frederick W. Cheney, *How Much Professional Liability Coverage Is Enough? Lessons from the ASA Closed Claims Project*, AM. SOC'Y ANESTHESIOLOGISTS NEWSLETTER, June 1999, http://www.asahq.org/Newsletters/1999/06_99/How0699.html (examining the “conventional wisdom” that physicians purchase insurance with \$1 million per-occurrence limits and \$3 million total annual limits); AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, MEDICAL PROFESSIONAL LIABILITY INSURANCE 7 (2004), <http://www.acep.org/NR/rdonlyres/DD94E243-339F-4A02-983D-7563D42BCE74/0/MPLIpaperApril04.pdf> (claiming that “[m]ost policies provide \$1 million for each incident with a maximum of \$3 million per policy period”).

114. Zeiler et al., *supra* note 8, at S32.

had limits of \$1 million.¹¹⁵ Six percent had limits of more than \$1 million, and 32% had limits of \$200,000 or less.¹¹⁶

Insurers in Texas are required to report the year in which a physician purchased the policy that covered the paid claim.¹¹⁷ These data allow us to estimate time trends in physician purchasing habits for policies covering large paid claims. Sample sizes for purchase years 1988–1999 were sufficient to estimate average limits. Figure 2 displays time trends in policy size by purchase year for perinatal and nonperinatal physicians.¹¹⁸ Real mean and medium limits on policies purchased by both perinatal and nonperinatal physicians who were later involved in large paid claims fell by roughly 30% from 1988 to 1999.¹¹⁹

FIGURE 2: PERINATAL AND NONPERINATAL PHYSICIAN
POLICY SIZE BY PURCHASE YEAR¹²⁰



Although our study did not investigate what might be driving the decline in real coverage, we offer a few conjectures.¹²¹ One theory,

115. *Id.*

116. *Id.*

117. *See supra* note 9.

118. While TDI does not require insurers to report the specialty of the physician against whom a claim is made, it does require reporting of the patient's age. We characterize all claims for injury to patients aged one month or younger at the time of the injury as perinatal claims. This allows us to estimate trends for a group of physicians thought to be hardest hit by the out-of-control liability system. *See Zeiler et al., supra* note 8, at S18.

119. *Id.* at S33–S34. Declines over time were statistically significant at the 1% significance level. *Id.*

120. *Id.* at S34 fig.9. Policies relate to single-payer cases resolved with a payment of at least \$25,000 in 1988 dollars.

121. *Id.* at S38–39.

consistent with observed trends, suggests that physicians purchase smaller and cheaper policies after realizing that exposure is minute even when coverage is low.¹²² While most managed care organizations and hospitals require their physicians to hold liability insurance, physicians are likely able to influence decisions over required coverage levels. Whether declining coverage is explained by something as simple as an increase in premiums or relatively cheap alternatives—e.g., asset protection strategies—or by a more complex story of strategic behavior on the part of providers, declining coverage reduces payments under the liability system. This, in turn, might limit the ability of the system to deliver just outcomes for injured patients.

IV. CONCLUSION

These findings, together with other published findings, help us evaluate whether and how well the medical malpractice liability system meets its primary goals: just compensation and deterrence. Contrary to the common rhetoric heard during tort reform debates, evidence suggests that the connection between the liability system and insurance markets is tenuous, which makes it unsurprising that tort reform has little to no impact on insurance markets. In addition, Texas closed claims data suggest that large jury awards, which get ample press, are often followed by much smaller payouts, a fact almost never accompanying news of jumbo verdicts. A large portion of the difference is attributable to the finding that patients rarely receive more than the provider's policy limits. This, coupled with the fact that Texas physicians are purchasing less real coverage over time, suggests that we might be facing a patient compensation crisis rather than a medical malpractice liability crisis.

While the data collected by the TDI have proven extremely useful for establishing a set of facts from which debates about how best to handle crises can begin, data on closed medical malpractice claims are rare. Either the data are not collected or they are collected but not made publicly available.¹²³ Academic researchers have a substantial

122. *Id.*

123. Florida and Missouri collect similar datasets and make them publicly available. Michigan collects closed claims data, but they are available only in paper form. Illinois, New York, Minnesota, Massachusetts, Nevada, and Washington collect closed claims data but do not allow the public access to them. Most states do not collect such data. The National Practitioner Data Bank (NPDB) also collects and allows public access to data on paid medical malpractice claims, although the data are not audited for completeness and accuracy. See Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 *LAW & CONTEMP. PROBS.* 59, 59 (1997); Joseph T. Hallinan, *Attempt to Track Malpractice Cases Is Often Thwarted*, *WALL ST. J.*, Aug. 27, 2004, at 1.

role to play in helping to increase the volume of available data, to establish factual baselines, and to study important yet unresolved questions. Involvement comes in many forms, including generating datasets from legal rules,¹²⁴ gathering data from market players,¹²⁵ and collaborating with organizations that work to increase the volume of available data that can be used to fashion more efficacious policy.

To this end, I and others have been working with the National Association of Insurance Commissioners to draft a model law that requires state departments of insurance to collect medical malpractice closed claims data from insurance companies and self-insured market actors.¹²⁶ The hope is that a substantial number of states will adopt the model law and that uniform multi-state data will be available to the public. Multi-state data would allow for a more sophisticated analysis of the causes of medical malpractice insurance crises (assuming they exist), the causes of medical error, and the impacts of tort reform on premiums, payments, and claims rates, just to name a few. Involvement by academics can mitigate, at least to some extent, the influence of industry actors who have strong incentives to keep the data private.

It should be noted that we do not know much about the generalizability of the results reported in the Texas studies. This is cause for concern as the state may differ in important ways from other states that experience severe fluctuations in medical malpractice insurance premiums.¹²⁷ In addition, all empirical studies are inherently limited due to missing observations, limited time periods, and other data imperfections. Studies produced using the Texas data, however, demon-

Despite these shortcomings, some have used the NPDB data to analyze medical malpractice liability trends. See, e.g., Avraham, *supra* note 48, at S183.

124. See, e.g., Avraham, *supra* note 24, at 116–18 (constructing dataset of tort reforms passed by state and by year, including results of judicial determinations of constitutional challenges to reforms).

125. See, e.g., Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 *LAW & SOC. REV.* 275 (2001) (employing qualitative data gathered from interviews of practicing medical malpractice attorneys to study why physicians tend not to pay out of their own pockets on claims with payments in excess of the policy limits); Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South*, 3 *AM. LAW & ECON. REV.* 199, 202 (2001) (using data obtained from a medical malpractice insurer to study the impacts of damage caps on payment severity).

126. A draft of the model law, guidelines for companion regulations, and opinion letters from interested parties—including physician groups, insurance companies, and academics—are available at http://www.naic.org/documents/committees_c_sitf_080221_Med_Mal_SITF_Request_closed-claim_reporting_model_law.pdf.

127. For example, Texas has one of the nation's largest homestead exemptions, which might make it relatively easy for doctors to protect at least some of their assets from attachment. See TEX. CONST. art. XVI, §§ 50, 51 (protecting homes from forced sale for the payment of most debts).

strate the value of observation in understanding whether the liability system enhances or limits civil justice for injured patients. Policy makers are more likely to implement effective solutions if debates stand on firm foundations that are established by facts rather than rhetoric.